Obst	1 (very good)	2 (excellent)	Enumerate
"A"			
Physiology & Mat adapat	Placental functions	- HCG in pregnancy - Changes in Cardiac system	- Anomalies of placenta, cor - Functions of Amniotic fluid
ANC	.Diagnosis of preg in 1st trimester .Calculation of EDD	- Comp. of young / old age - Comp. of GMP / elderly PG - Routine investing. in preg	- Sure signs of preg - Causes of non-engagement - DD of FL > or < amenorrhea
BLin early preg	- Threatened, missed, septic - Patulous os/ habitual abortion - Ectopic (diagnosis / ttt)	- Management & follow up of Vesicular mole	- Clinical types of spont ab - Causes of habit. abortion - Risk factors / fates of ectop
APHge	P.previa (diagnosis / ttt) Acc. Hge (comp)	- Vasa previa	- Risk factors/comp of acc.hg
PPHge	- Atonic PPhge - Retained placenta - Complete perineal tear - Rupture uterus - 2ry PPhge (causes / ttt)	- Obstetric trauma: . Maternal . Fetal birth injuries	- Causes of 1ry PPHge - Causes of 2ry PPHge - Comp of rupture uterus - Causes of shock in obst - Causes of postpartum colla
Dis with preg	- PET (diagnosis / ttt) - Eclampsia (diagnosis / ttt) - DM (comp: infant of diabetic) - Hyperemesis gravidarum	. Anemia } usually . Heart dis } clinical cases	- Criteria of severity of PET - Comp/ bad signs of eclamp - Comp of DM (fetal/ newbor - Pdf for pyelonephritis - Abd. pain with pregnancy
"B"			
abor	- Diagnosis of onset of labor - Management of 3rd stage - OP: management - Breech: retained coming head - Transverse lie: causes / ttt	. Diameters of head & pelvis . Partogram (active manag)	- Etiology of . OP . Breech . Transverse lie - Causes / comp of obst labo
ontracted p.		Types & management	- Pre-requites for trial of lab
Abn. ut action	Obstructed labor		- Classification of abn.ut.ac
Fetology	Biophysical profile U/S - IUGR - Macrosomia / should. dystocia - PTL (causes / ttt) - Twins (diagnosis / comp) - Rh incomp	- Newborn . RDS . Neonatal asphyxia - Puerperium .Puerperal pyrexia, sepsis .DVT with pregnancy - Operative .Episiotomy: ind /comp/ type .Forceps: prerequisites /com .Comp of CS / VBAC	- Parameters of BPP - Indications of amniocente - Causes of elevated α-FP - Apgar score - Causes of fetal distress - Diagnosis of IUFD - Causes of PTL / IUGR - Causes / comp of oligohy - Causes / comp of polyhdr - Comp: twins / PROM / ma

3 Q.....18 min.....30 marks

General			Obstetrics		Gynecology
			1%.....10%.....50%.....90%		
1	Def. & %	1	*Maternal* (mother, uterus) *Fetal* (fetus, pl., AF, cord)		.Infection (org.,route.,PDF) .Tumor (hyperestrogenemia) .Endocrine (anovulation)
2	Etiology				
3	Pathogenesis	2	Unknown (theories), familial, idiopathic, iatrogenic		
4	Pathology				Mac...mass, ulcer, infiltrat. Mic...atypia (cellular, archit)
5	Clinical picture	3	*Symptoms* .Amenorrhea .Pain .Bleeding .Sympt. of comp. *Signs* .General ..of comp .Abd.... 4 grips + FHS .local... PV		*Symptoms* . Bleeding . Swelling . Pain . Discharge *Signs* . General . Abd . Local
6	D.Diagnosis		To the major sympt. / sign		
7	Investigations	4	Aetiology FWB ..... late Complications Diagnosis.....U/S + β-HCG RoutineE....early		- Screening - Diagnostic...invasive / not - Preoperative - Metastasis.....OR (*α: lab, scan, scope, biopsy*)
8	Complications		*Pregnancy*.....P *Parturition* .1st.....PROM, .2nd ...obst. .3rd .....PPhge *Puerperium*....3S	*Fetus* .CFMF .IUGR .IUFD .PTL *Labor*..5	The most common The most serious .Anesthesia .Hge .Infection .Injury
9	Treatment	5	*Conservation* .Why.....not severe yet .Where ..ANC, Hospital .How.....control disease detect comp. TOP .Why.....severe .How.....VD / CS		*Medical* .Hormonal....COC, clomid .Medical.....anti-PG *Surgery* .Conservative...young .Radical.....old *Follow-up* *Prognosis & recurrence*

Case 1

A G4 P3, 30 yrs old is now 34 wks pregnant & presented with mild vaginal bleeding for 1 week with no pain. All previous deliveries were conducted at home normally but without ANC. On examination BPr: 110/70, Pulse: 90 bpm. The fundal level is 2 fingers above umbilicus, cephalic presentation & FHS were regular. Inspection of vulva revealed mild bleeding. Hb 9.7 gm%. Two days ago she complained of decreased fetal kicks. CTG on 20 minutes showed no accelerations or decelerations with good baseline variability.

- **State your final diagnosis** G4P3 · 34wks cephalic not in labor
- **When are you going to deliver her**
  - • → Distress, spots blood
  - • → severe
  - • → mature
- **How are you going to deliver her**
  - minor case → mild → VD or
  - major case → C.S or
- **Does this fetus needs special management? Why?**
  - Drugs → Vit E, hapoxin, cortison, Aspirin
  - Follow up →
- **Will you consent for hysterectomy during delivery? Why?** fear of postpartum hge.
- **Define maternal mortality**

The death of any woman d.t. any cause (in preg. & puerp.)
Regardless the duration or site of pregnancy
From any cause related or aggravated by preg. or its management
But not from accidental or incidental causes

$$MMR = \frac{\text{number of maternal death in one year}}{\text{number of total births in the same year}} \times 100.000$$

Case 2

A 38 age woman is in labor one she suddenly collapse. She is G5 P4 and arrived at hospital at 42 weeks with 3 cm dilated cx and intact membranes. Augmentation of labor was decided by 5 units oxytocin by infusion drip. Five minutes ago spontaneous ROM occurred during a contraction, with a large gush of clear fluid from the vagina. The woman reported an urge to push at that stage where she became confused and disoriented. She delivered a baby boy with APGAR 2 at 1 min and 6 at 5 min. The patient was immediately transferred to ICU due to severe PPHge where BPr 80 /40, pulse 140 bpm, oxygen saturation 80%.

- **Discuss a 2 possible differential diagnosis** Rupture UT, Amniotic embo

edema → pre eclampsia
→ CPD (obstructed labor)

Case 3

A 39-year-old G6 P5 in labor was attended at home. On examination the midwife was suspecting a breech presentation. The patient was transferred to hospital after failure of delivery for more than 24 hours. At the labor ward, pulse was 120 b/m, T: 38.2, BPr 125/80, acidotic breathing, FHS are heard 142 bpm. On P/V edema of the vulva is found, Cx is fully dilated and the presenting part is very low. A bedside U/S confirms cephalic presentation but the head appears markedly deflexed and obscured by edema. Delivery does not ensue over the coming hour despite frequent contractions and good maternal effort.

- What was the presenting part Face presentation
- What is the most serious complication for such a case? How to diagnose it?
  - general • → collaps
  - Abdomen • → T. R, T R, fetal Early fall
  - Local • → Bleeding. (Rupture)
- How to avoid such complication?
  - Ant N Care • →
  - Intra Natal • →
- How are you going to deliver this case? Upper C.S. with Bilateral Tubal ligation.

Case obst 4

A 25-year-old G3 P2 is admitted to the labor ward with a 10-day history of reduced fetal movements. She is currently 32 weeks pregnant, and her dating and detailed ultrasound scans were entirely normal. On Examination her uterus is tense but not tender, and her fundal level is reaching xiphi sternum. Her BP is 110/65mmHg, pulse is 92 bpm and urinanalysis reveals +++ of glucose. A CTG is performed and is found to be normal.

- What is the most probable diagnosis gestational D.M. complicated to chronic? Poly hydramnios
- Discuss differential diagnosis
- How to follow up such a fetus & such a mother

mother → D.M. ↑
poly hydramnios → Ant. P.G, Amniocentesis

Case 5

A 30 year-old G4 P3 woman at 39 wks gestation is undergoing a vaginal delivery. She has a history of previous myomectomy and one prior low transverse cesarean delivery. The delivery of the baby is uneventful. The placenta doesn't deliver after 30 min, and a manual extraction of the placenta is undertaken. During the procedure, the patient pulse becomes thready 140 bpm with rapid drop of pressure to 60/30. Abdomen becomes increasingly rigid.

- What is the most likely diagnosis? R uterus.
- What is your next step in management for this patient?
  No Repair & hysterectomy & No oophrectomy

Case 6

A G3 P2, 30 yrs old lady is presented at her 34 weeks' gestation. She gave birth to a living female 4.5 kg 6 years ago. Her 2nd pregnancy ended at term by IUFD almost the same weight.

On examination: BMI 33 kg/m^2, BPr: 140/90, there is edema in both lower limbs reaching to the knee. Abdomen is tense reaching xiphi-sternum with difficulty in palpating fetal parts and a positive fluid thrill. Urinanalysis was free. Recurrent G D.M. complicated by chronic poly hy

- What is the single test to confirm her long standing condition Hb A1c
- Explain why ready neonatologist should be available after delivery
  - 3 ⬆
  - 3 ⬇
  - 3 ➡
- What is the precaution taken if the patient is going to deliver vaginally elective C.S controlled R.O.M.
- What are the possible causes of this enlarged abdomen? Poly hydramnios.
  - ➡
  - ➡
  - ➡

Case 7

A para 4 diabetic gave birth to a baby by vacuum extraction due to prolonged 2nd stage of labor. After delivery of the fetal head, the usual downwards traction of the head failed to complete the delivery

- What are the 2 possible causes for this condition
  shoulder Dystocia , anencephaly.
- What is the probable management under anesthesia & convulsant
  1- supra pubic pressure
  2- episiotomy
  3- Mac Roppen
- What are the possible complications
  1- PPHg or Puerperal sepsis, Rupture
  2- Rupture
  3- Asphyxia, injury, Death, infection.

Case 8

A 25 year old gravida 3 para 2 noticed vaginal spotting at 28 weeks for which she was hospitalized. The abdomen was noted to be too large for date and U/S detected twin gestation. Bleeding stopped spontaneously & the patient was discharged upon her request 24 hours later. At 30 wks, she was transmitted to hospital complaining of vaginal bleeding. On examination, uterus was found contracting once / 10 min

- What is your final diagnosis ---- = Twin, APHge, complicated by preterm labor
- What are other causes of such condition(s)?? causes of PTL, P.D, Twin.
- How to manage such a case
- What are the tocolytics to be avoided here Ant. PE → Ex B_2 agonist → ↑ puls.

Case 9

A 30 years old G5 P4 woman at 32 weeks gestation complains of significant bright red vaginal bleeding. She denies uterine contractions, leakage of fluid or trauma. The patient states that 4 wks previously, she experienced some vaginal spotting after engaging in sexual intercourse. On examination, BPr 110/60, pulse 80 bpm, temp 37.1, heart & lung examination are normal. The abdomen is soft and uterus non-tender. Fetal heart tones range from 140-150 bpm

- What are clues from history to justify your diagnosis → g.
- What is your long-term management
- What is the DD of such a case

Case 10

10 w + 5 day

A 25-year old housewife, her LMP was on 1/6. On 16/8, she had a dark brown vaginal bleeding associated with bouts of lower abdominal colic and discomfort. Urine tests for pregnancy was +ve. The patient was advised to have bed rest and to take long acting progestogen IM twice weekly for two months. The bleeding & pain gradually disappeared.

21 w 5 day On 2/11, she attended the ANC & she was worried because she had not felt any fetal movements and her gums easily bleed. The FHS could not be heard with the portable Doppler machine. The patient refused P/V examination

- What is the EGA for this patient today? How to confirm its accuracy? = / /
  - examined → fundal level (فاكسى) الحمل مات
  - IMV →
- State 2 important investigations to confirm your diagnosis?
  - U/S →
  - fibrinogen →
- What are the other causes of bleeding gums in a pregnant female DIC

Hypertensive	Death	Transfusion
-	-	-
-	-	-
-	-	-

- Suggest a plan of management
  - fibrinogen →
  - Termination → P.G E1

Case 11

A 36year-old woman delivers spontaneously at 33 weeks gestation, having had pre-labor pre-term rupture of membranes from 29 weeks gestation. She is re-admitted to the post-natal ward one week later with marked dyspnea. Abdominal examination showed uterine fundus is palpable at the level of the umbilicus which was tender. On P/V examination there was intense warmth, tissue dryness but there was no discharge. Both lower limbs were edematous.

Retained fluid of الحمل → DVT دليل

- What is the most probable diagnosis puerperal sepsis

Case 12

A 20-year-old PG at 38 weeks gestation is admitted to the labor ward with fresh vaginal bleeding. Her membranes ruptured 20 min ago and she started bleeding immediately after rupture. On examination her uterus is soft, her BP is 132/75 mmHg, pulse is 88 bpm and temperature is 37 C. The FHR is 90 bpm. Urinanalysis is clear.

- What is the most probable diagnosis Vasa previa
- Discuss differential diagnosis Ant pot hge

Case 13

A 39-year-old G6 P1 with a BMI 29, who has had 4 miscarriages in the past and a pulmonary embolism during her last pregnancy, is admitted to the labor ward with abdominal pain and vaginal bleeding at 35 weeks gestation. Her BP is 148/98 mmHg, and urinanalysis is ++ protein. She undergoes an emergency CS for suspected placental abruption. The baby's weight is below the 5th percentile, and the placenta is small with multiple thrombi and infarcts.

- What is the most probable underlying cause? Antiphospholipid S

Case 14

A 22-year-old G2 P0 is admitted to the labor ward at 42 weeks gestation in early labor, having ruptured membranes 48 hours earlier. She makes very slow progress and her labor has to be augmented with oxytocin. She complains of severe backache throughout. The presenting part remains high, with 2/5 of the head palpable above the pelvic brim.

- What is the most probable underlying cause? O.P

Case 15

A 24- year old PG presents to emergency at 32 weeks gestation with a history of acute abdominal pain. She is agitated and confused, and she also has headache and severe nausea. Her blood pressure is 130 /85 mmhg and urine analysis shows +1 proteins. Her initial blood results: Hb 7.7, CRP 100 units, AST 180 IU, ALT 600 IU, bilirubin 22 mg %

- What is the best management? HELLP S

Mg salphat & Ant hypertns

Case 16

A 40 year old patient, had five normal deliveries and three spontaneous abortions. The last abortion was 8 months ago. She is complaining of prolonged irregular vaginal bleeding for the last few months.

Suddenly in the last few days, she had hemoptysis & vaginal examination revealed a slightly enlarged uterus. Pelvic U/S showed bulky uterus with irregular uterine cavity and bilateral cystic ovaries 4x5 cm

- What is the most likely diagnosis choriocarcinoma
- How to confirm
  - BHCG →
  - Pelvis →
  - CXR →
- What is the ideal treatment chemotherapy.

hysterectomy ← chemo Hx of intolerance / complications / completed her family

Case 17

A 19 year old PG has come to the RR with severe vaginal bleeding of one hour duration. She is pale with BPr 90/50, pulse 120 and T 36. Her LMP was 10 wks earlier but the fundal level is at the umbilicus. An immediate U/S scan was ordered and the uterus was markedly enlarged with no fetus inside. The ovaries were also enlarged.

The patient was then treated and was scheduled for follow up. Three days later, the patient developed severe lower abdominal pain and laparotomy was performed to remove an ovary

- What is the most likely diagnosis V.M complet molo & Bilateral Theca lutine cyst
- What was the initial ttt and how you follow up this patient
  - →
  - →
- What was the possible picture seen in the uterus by U/S
- What has happened to necessitate laparotomy?

- If the patient hadn't developed an acute abdomen, how would you manage the enlarged ovaries

Case 18

A 19 year-old lady cornplained of 2-days history of vaginal spotting & lower abdominal pain. She states that her period is 2 weeks late. On examination BPr. was 130 /70, pulse 70 bpm, temp 37°c. Abdomen is non-tender, no masses are palpated.

Pelvic examination reveals a bulky uterus which is not tender. there were no adenexal masses. Quantitative β-HCG level is 900 mIU/ml. transvaginal U/S revealed an empty uterus with no adnexal masses.

- What is your provisional diagnosis?
  - →
  - →
- What is the next step in management? Follow up
  - β-HCG → doubling /subnormal rise / reaches transitional zone
  - TVUS →
  - Hct % →
  - Clinical → adnexal swelling felt or acute abdomen occurs
  - Laparoscopy → both diagnostic & therapeutic

Case 19

A 36 year old para 5+2 has presented to the RR with repeated attacks of abdominal pain for the last 2 days. She has had an IUCD applied 8 months ago and she states that her period is 6 days late.

Three hours ago, she had a syncopal attack and has now begun to feel pain in her right shoulder. T 36.2, BPr 90/60, pulse 100 b/m. The abdomen is markedly tender esp in the lower part. On PV examination, there was marked tenderness

- What is the most probable diagnosis ectopic (Cervix Displaced)
- What is the probable etiology for the shoulder pain
- Could the IUCD have a role in this story? How?
  - infection →
  - Miscarriage →
- What are other contraceptives may lead to such a condition POP
- If this patient is NG, would this differ your management, how?
  - old →
  - young →
- Choose a suitable method for contraception for further use for this lady

Case 20

A female aged 32 years complained of delayed period for two weeks. Pregnancy test was +ve, U/S scan reported the presence of intrauterine retained products of conception.

A D&C and biopsy were performed. Pathology report indicates the presence of polypoidal hyperplastic endometrium only. Suddenly 3 weeks after the D&C, the patient collapsed at home with pale cold clammy skin.

Comment... missed ectopic pregno & arastella Reaction.

Case 21

A 35 year-old woman, 8 weeks' pregnant complained of crampy lower abdominal pain & vaginal bleeding. She stated that the pain was intense in the last night followed by passage of a large blood clot. After that both pain & bleeding subsided.

On examination BPr. was 110 /70, heart rate 70 bpm, temp 37.5. Abdomen is non-tender, no masses are palpated. Pelvic examination revealed a 6-week sized uterus which is not tender, there were no adenexal masses. The cx was closed & non-tender.

- **What is the most likely diagnosis?** complete # incomplete abortion
- **What is the next step in management?** U/S
  - If no remnants →
  - If remnants are small →
  - If large remnants ± bleeding →

- **What are the complications of evacuation?**
  - Anesthesia complications
  - Hge & infection
  - Injury → perforation
  - Later on → Aschermann syndrome

- **What are the pdf for perforation?**
  - Soft, friable uterus (pregnancy....infection... malignancy)
  - Doctor inexperience (excessive force or wrong direction)

Case 22

A 16 year-old un-married teenager underwent D&C for an incomplete abortion 3 days previously. She complained of continued vaginal bleeding & lower abdominal cramping. Over the last 24 hours, she noted significant rise of temperature together with shills. On examination BPr. was 90 /50, heart rate 120 bpm, temp 38.6°c. Cardiac examination reveals tachycardia, lungs are clear bilaterally. There is moderately severe ower abdominal tenderness.

Pelvic examination showed a cervical os opened 1 & ½ cm, together with uterine tenderness. The TLC is 20.000 /mm3, Hb level was 11 gm/dl. Urine analysis showed 2 pus cells/ HPF.

- **What is the most likely diagnosis?** *Septic abortion*
- **What is the next step in management?**
  - ICU transfer ⇐⇒ elevation of the general condition
  - U/S to detect ⇐⇒ remnants in the uterine cavity
    ⇐⇒ suction evacuation is better than D&C

Case 23

A 22 year-old G2 P0+2 woman at 7 weeks gestation by LMP complains of vaginal spotting. She denies the passage of tissue per vagina, any trauma or recent intercourse. Her medical history is significant for pelvic infection after using an IUCD one year ago. On examination BPr. was 100 /60, heart rate 90 bpm, temp 36.8°c. abdomen is not tender with normal active bowel sounds.

On pelvic examination showed the cervical os closed & non-tender, uterus is 4 weeks size with no adnexal tenderness. The quantitative β-HCG is 2300 mIU/ml. Transvaginal sonogram reveals an empty uterus with no adnexal masses

- **What is the most likely diagnosis?** *ectopic*
- **What is the next step in management?** *methotrexate*
- **Would you conserve or remove the tube?**
  - If tube is not damaged → salpingotomy
  - If tube is damaged → salpingectomy (preferred now by many)
- **Would you conserve or remove the ovary?**
- **when to offer medical therapy?**
  - Sac size < 3 cm + no cardiac activity (non-viable)
  - β-HCG < 3000 mIU/ml
  - Patient haemodynamically stable
- **What is the prognosis?** 15% recurrence.....30% infertility

Case 24

You are asked to review a 31-year-old nulliparous woman in the early pregnancy clinic. She first attended the clinic 7 days ago at 5 weeks amenorrhoea with mild right iliac fossa pain and vaginal spotting. A transvaginal U/S has revealed an empty uterus, and 3 serum b-HCG levels performed at 48 hours intervals have been reported as 505, 700 and 895 IU/L, respectively.

- What is the most probable diagnosis? ectopic
- What is next step?

Case 25

A 23 yr-old G2P1 woman at 14 wks gestation complains of 12 hour history of colicky right lower abdominal pain together with N&V. she denies vaginal bleeding or leakage of vaginal discharge. She denies diarrhea or eating stale foods. She denies dysuria or fever, and she has had no previous surgeries. BPr 100/70, pulse 105 bpm, RR 12/m, temp 37.3. On abdominal examination, her bowel sounds were hypoactive. The abdomen is tender in the right lower quadrant region, with significant involuntary guarding. PV examination showed closed cervix, and fullness of Douglas pouch. Gentle bimanual examination showed right sided swelling related to the uterus. U/S showed viable intrauterine pregnancy.

- What is the most likely diagnosis? ~~appendicitis~~ rupture of ovarian cyst, fibroid, adhesions
- What is your differential diagnosis? UTI
- What is your next step in management for this patient?

Case 26

A 17 year teenager underwent medical TOP for an illegal 8 weeks pregnancy. She then bleed continuously for 3 weeks. U/S was done & showed a 50 x 20 mm retained products inside the uterine cavity. Three days after evacuation, she was transferred to the hospital with a generally ill & pale outlook. Examination showed Temp 38.5, intense abdominal distension with diffuse abdominal rigidity. She didn't pass flatus since the operation.

- What is the possible diagnosis Perforation of uterus & intestin.
- What is the best management
- How to avoid such complication

Case 27

A 17 year teenager underwent E&C after being raped. She then bleed continuously for 3 weeks. U/S was done & showed a 4x2 cm retained products inside the uterine cavity. Another E&C was decided to remove these remnants. However, the patient was still bleeding postoperatively for 5 weeks. U/S was redone and showed a similar picture so a 3rd evacuation was done. Now the patient is represented to the emergency room with marked pallor, pulse 120 bpm. U/S showed a bulky uterus with a fundal intramural mass 4x2 cm.

- What is the possible diagnosis choriocarcinoma
- What is the best management
- How to avoid such complication

Case 28

A nulliparous 21 year old lady represents with abdominal pain occurring for the past 4 hours. She gives a history of fainting. She has a +ve pregnancy test. She has irregular periods and cannot recall her LMP. U/S showed a thick endometrium with no fetal pole inside the uterus. There is a small amount of free fluid in Douglas pouch. She complains of right adenexal pain with tenderness & rigidity. She is tachycardic and has normal blood pressure. Serum HCG is 2300 IU and Hb level is 9.5 mg%

- What is the best management Distended abd

Case 29

A 25 year old woman at 11 wks gestation complains of severe abdominal pain and feeling faint for the last hour. She had moderately vaginal bleeding that began yesterday morning. She is rheumatic with past history of mitral valve replacement and is receiving marivan 3 mg once daily. On examination: BPr 90/60, pulse 120 bpm, temp normal. Her abdomen is diffusely tender, distended with rebound tenderness and a fluid wave is present. The cervix is closed but there is boggy fullness of the Douglas pouch U/S → 11 wks

- What is the most likely diagnosis? ruptured CL cyst due to anticoagulation (marivan.)
- What is your management for this patient?

Case 30

A 25 year old para 4+2 has come to the clinic as she has no living children. Her 1st pregnancy was 9 yrs ago and ended in the delivery of a fresh stillborn child by CS for APHge. The next child was alive but rapidly developed jaundice and died 2 days after. The 3rd & 4th pregnancies ended in stillbirths at 38 & 34 weeks maturity. Both were cases of hydrops fetalis

Now, she is 30 wk pregnant and on doing routine investigations she is found to be Rh –ve and sensitized with a titer 1/512

- **What could have been done to prevent fetal losses**
- **What is meant by hydrops fetalis? What are the other causes?**
- **Would the present fetus be necessarily affected & why?**
- **How would you manage such a case?**

Zone	Hemolysis (HB%)	Repeat after...wks	Delivery at
1. Low (a)	> 13 gm%	3	term
2. Mid (b): Low	11–13	2	37 – 39
High	8 – 11	1	35 – 37
3. High (c)	< 8 gm%	Rapid intervention	

Case 31

A 24 year old woman G2, P1 at 30 weeks gestation was admitted 2 days ago for PROM. Her antenatal history has been unremarkable. She states that she has no fever or chills and baby is moving well. On admission BPr was 110/70, pulse 90 b/m, T 37.9

One day later, uterine contractions started regularly every 5 min & on examination cervix was found to be 2 cm dilated. The patient was put on tocolysis, but during therapy temp has been found 38.9

- **What are the risk factors for PROM**
- **Was the initial conservation for this patient correct? Why?**
- **Was the management for uterine correction correct? Why?**

Improve general condition & Terminate. C.S.

Case 32

A 32 years old, PG, married for 2 years, her L.M.P was on 22/4. During the course of pregnancy she suffered from recurrent UTI, on 2/11 her B.P was elevated to 160/95 with heavy proteinuria.

- **Why UTI is common in pregnancy**
- **What is the DD of proteinuria with pregnancy**
- **How to screen for development of PET & what is the prophylaxis**

Case 33

A 19 year old PG pregnant at 36 weeks has been admitted in labor with severe headache & blurring of vision for the past 6 hours.

On examination BPr 180/120, pulse 96 /m. Abdominal examination shows a fundal level corresponding to 34 wks of gestation with uterine contractions 3/10 min, FHS 140 b/m. PV showed a cervix 7 cm dilated, vertex presentation, with well engaged head.

Urine analysis: proteinuria ++. The patient was put on medical therapy under observation expecting delivery within 3 hours

- What was the medical ttt given
  -
  -
- What observations were performed
  - General →
  - Local →

One hour later, the patient developed severe lower abdominal pain & the FHS rapidly dropped to 100 b/m. On vaginal examination there was no bleeding and the cervix was now 9 cm dilated

- What is the most likely cause of pain
- How could you manage such a case
  - General →
  - Local →
    - Electric monitor
    - Fetal scalp ph

Case 34

A 32 year old Para 3+0 has come to the hospital with severe dyspnea & proved to have pulmonary edema. She has had mitral stenosis for the past 20 years and is now pregnant at 10 weeks

- What be the proper management of her case
- If the patient were pregnant at 20 wks would the management be different? How & why?
- If the patient were in labor, what would be the proper management
- Name a vulvular lesion which would be an indication for CS

Case 35

A young PG 17 yrs old, 36 wks pregnant was admitted with a history of 2 consecutive fits at home. On admission the patient was conscious, but with incoherent speech, BPr 140/110, pulse 100b/m T 37.2. There is peri-tibial edema, urine was albumin +. By abdominal examination, the size of the uterus correspond to the duration of pregnancy, FHS were audible, cephalic presentation. **Comment**

Case 36

A 37 year old PG pregnant at 34 weeks presented to the RR with upper abdominal pain. On examination her blood pressure was 170/110 mmhg, edema of lower limbs and tinge of jaundice was observed

- **What is the probable diagnosis?** *edema oedème cervicale*
- **What investigations would you perform to certify the diagnosis**
- **What is the plan of managent?**
- **What are the other causes of jaundice in pregnancy?**

Pregnancy induced	Pregnancy associated
- PIH & HELLP syndrome	- Hemolytic J.
- Severe hyperemesis gravidarum	- Obstructive J.
- Intrahepatic cholestasis of preg	- Hepatocellular (VH, cirrhosis)
- Acute fatty liver of pregnancy	- Drugs

Case 37

A fifth gravida at 36 weeks pregnancy is transferred to the hospital in a state of shock after falling on her abdomen. on examination, the patient was drowsy, the abdomen is extremely tender and the FHS are not heard. Vaginal examination showed moderate vaginal bleeding & closed cervix.

- **State 2 probable causes**
- **Mention causes of shock in pregnancy**
  - **Hgic shock** ⇨ bleeding in early preg., APHge, PPHge
  - **Hypovolemic** ⇨ dehydration (hyperemesis gravidarum)
  - **Neurogenic** ⇨ pain in early preg., pain in late preg.
  - **Septic** ⇨ septic abortion, chorioamnionitis, puerperal sepsis
  - **Splanchnic** ⇨ sudden drop of intrauterine pressure (polyhdramnios, twins)
  - **Pulmonary embolism** ⇨ amniotic fluid or thrombus

Case 38

A 28-year-old PG is admitted to the labor ward at 34 weeks gestation with reduced fetal movements for 24 hours. On examination her uterus is non-tender and her fundal level is 3 fingers above umbilicus. BP is 154/96 mmHg. pulse is 104 bpm and urinanalysis reveals ++ proteins. CTG reveals a reduced basal line variability and absence of accelerations over a one-hour period.

Establish your management severe PET

Case 39

A 25 year old PG has noticed a sudden gush of watery vaginal discharge and she has come to the hospital. She is now pregnant at 32 wks. BPr 120 / 70. pulse 75. T 36.5. Her fundal level is at 30 wks.

It was decided not to perform a vaginal examination and the patient was put under observation after confirming the diagnosis to be PROM

- **How would you confirm the diagnosis?**
  - Non-invasive → Strip casco
  - invasive → Amniography
- **Why vaginal examination was not performed?**
- **What observations & investigations should be performed?**
- **For who long should be the patient kept under observation?**
  - Disease →
  - Mother →
  - Fetus →

Case 40

After a 9 hour labor, a Gravida 4 Para 0+3 have undergone a vaginal delivery giving birth to a living male 3.6 kg. Placenta failed to be delivered for more than 30 minutes. The patient was transferred to the operative theatre & manual separation under anesthesia was decided. Laparotomy was then done due to failure of that procedure.

After the operation, the patient stated that her previous abortions were due to uterine anomalies.

- **What is the possible cause for retained placenta here?**
- **What are the hazards to remove the placenta manually?**
  -
  -
  -
- **What will be done in the laparotomy?**

Case 41

A 23 year old G1 P0 woman at 40 wks gestation is undergoing labor induction with syntocinon for oligamnios. She has been at 8 cm for 1 and 1/2 hours. A mild degree of caput is noted on cervical examination. The baby is presented cephalically with his vertex at station +1. Her uterine contractions are every 4-6 min and palpate firm each lasting for 30 sec. The EFW is 3.3 kg and the pelvis seems clinically adequate. The fetal heart tones range from 145-150 bpm. However the last 30 min twice a time there was sharp decrease of FHR to 90 bpm for 5 sec with spontaneous resolution. There was no loss of beat to beat variability. cord compression

- What is your next step?
- What is the most likely diagnosis?

Case 42

A healthy 19-yr old G1 P0 at 29 wks gestation presents to emergency department complaining of intermittent abdominal pain. She denies leakage of fluid or bleeding per vagina. Her antenatal history is unremarkable. On examination BPr 110/70, pulse 90bpm, temp 36.9. The FHR tracing reveals a baseline of 130 bpm and a reactive pattern. Uterine contractions are occurring every 3-5 min. on PV, her cx is 3 cm dilated, 80% effaced, and the fetal vertex is presenting at -1station PTL & Tocolyt

- What is the most likely diagnosis?
- What is the etiology of such condition?
- What is your next step in management for this patient?

Case 43

A 22 year-old G3 P2 at 40 weeks' gestation complains of strong uterine contractions. She denies leakage of fluid per vagina. She denies medical illness. Her antenatal history is unremarkable.

On examination, her BPr is 120/80, hear rate 85 b/m T 37. The FHS ranges from 140-150 b/m, the cervix is 5 cm dilated, and the vertex is at -3 station. Upon artificial ROM, fetal bradycardia ranging from 70-80 b/m without recovery

- How to confirm the diagnosis
- What are the causes of such condition
  -
  -
- How to deliver her
- What will you do until delivery

Case 44

A young para 4 lady was attended by a mid-wife at home. The whole delivery has taken less than 2 hours. Immediately after delivery, the patient collapsed.

The patient was transfe-red to hospital, on examination abdomen was found lax but the uterus was not felt. Vaginal examination revealed no bleeding but the-e was a reddish bulging mass is noted at the introitus

- What is the probable diagnosis?
- What is the DD of swelling protruding from the vulva
- Why there is no vaginal bleeding
- How to manage such a case?
- What are the causes of postpartum collapse?
  - Obstetric → - Primary PPhge -,-,-,-,-
    - Eclampsia
    - Pulmonary embolism (d.t. amniotic fluid or thrombus)
  - Non-obst → . Cardiogenic shock e.g. peripartum cardiomyopathy
    . Cerebrovascular accidents
    . Anesthetic complications e g. Mendelson syndrome

Case 45

A 23 year old G1, P0 woman at 40 wks pregnancy is undergoing induction of labor with oxytocin for oligohydramnios. She has been at 6 cm dilatation for 3 hours. A significant amount of caput is noted on cervical examination. Her uterine contractions are every 6 minutes, each lasting for 40 seconds. The estimated fetal weight is 3.7 kg and the FHS ranges from 145-150 b/m

- What is the diagnosis
- What are the possible causes
  - General →
  - P
  - P
  - P
- What are the types of caput
  -
  -
- How to manage such a case
  - Correct any possible etiology
  - Continue with proper monitoring
    - Clinical → partogram
    - Electronic → intrapartum monitoring

Case 46

A 25 year old PG has been in labor for 18 hours, vaginal examination revealed vertex presentation with right occipito transverse, station of the head at +2 and the head is well moulded with mild caput. The cervix is fully dilated and the membranes ruptured 6 hours ago.

- What is the most likely diagnosis Deep T Arr Partogram.
- How to detect this problem earlier
- What is the best management of this case if there were late decelerations in the last 30 min
- What is the best management of this case if there were early decelerations in the last 30 min

Case 47

A PG, 26 yrs old, married for 2 yrs. When she was 33 wks pregnant, she experienced severe diffuse abdominal pain with no vaginal bleeding and the fetal movements stopped. Two hours later she was transferred to hospital with BPr 80/50 Pulse 110 b/m T 36 & very pale. Uterine fundus reached the xiphi-sternum, very tender uterus to the extent that you can feel the fetal parts. FHS not audible & the cervix was closed with no bleeding

- What emergency measures you are going to take
- What's your provisional diagnosis, why?
- What are the other causes of acute abdomen with pregnancy

❶	Pregnancy	
	☆ Early	Abortion, ectopic, incarcerated gravid RVF uterus
	☆ Late	Accidental hge. rupture uterus, acute fatty liver, acute polyhdramnios
	☆ Masses	- Complicated ovarian (ruptured CL cyst or TL cyst of V.mole) - Complicated fibroid (red degeneration)
❷	Urinary	Cystitis, pyelonephritis, stones (renal colic)
❸	GIT	Gastroenteritis, viral hepatitis, food poisoning
❹	Surgical	Acute appendicitis, acute cholecystitis, perforated DU
❺	Medical	DKA, sickle cell crisis, acute porphyria, mesenteric vasc occlusion

Case 48

P3, one living male child. all deliveries were SVD, the 1st & last babies died in-utero, now presented at your clinic with decreased fetal kicks over past few days. FHS was +ve BPr 110/70, pulse 90 /m she is 32 weeks by date & FL was equal to her period of amenorrhea.

What is your management

- Admission
- Search for etiology
  - Maternal ➡
  - Uterine & placental ➡
  - Fetal ➡
- Follow up + steroids
  - History ➡
  - Examination ➡
  - Investigation ➡ Doppler + CTG

Case 49

PG delivered spontaneously a living male baby at her home with retention of placenta, and then transferred to hospital with postpartum hemorrhage, manual separation of placenta was done but she developed puerperal pyrexia & followed by 2ry amenorrhea.

- **What is the possible cause of p.pyrexia?**
- **What are the other causes**

1- P. sepsis → ✓ .... the most serious	4- DVT
2- Breast → ✓ ... the most common (engorgement, mastitis, abscess)	5- Complication in associated genital tumor
3- Infections e.g. UTI or wound inf.	6- Lung atelectasis

- **What is the possible cause of this amenorrhea**

Case 50

A PG, 30 years old, 36 wks pregnant. Her B.P. was 155/95 starting from the 26th week of pregnancy but she wasn't edematous. The ultrasonic report estimated the fetal weight 1.600 kg with positive turbidity of the amniotic fluid, atherosclerotic changes of placental blood vessels and the fetal life was positive.

- **What further investigation you need to diagnose the case?**
- **This fetus is in danger, what is it?**
- **How are you going to conduct the delivery of this case?**

Case 51

In the obstetrics emergency room, the ambulance brought a 36 years old para 4 woman with fetal buttocks, body and arms coming out of the vulva. On examination T 37.8, pulse 110 bpm

- What are the possible causes
- Discuss the management of such a case

Case 52

A 29 yrs old G3 P2 at 38 wks gestation had a myomectomy 3 yrs ago. She was admitted at the delivery room with spontaneous onset of labor. While she was pushing in the 2nd stage, she's noted to have fetal bradycardia associated with some vaginal bleeding. then the fetal head was at station +2 became now at -3 station. Abdominally fetal parts were easy to be felt but with no audible FHS

- What is the most likely diagnosis
- What are the possible lines of management
- How to avoid such problem

Case 53

A 29- year old woman at term is admitted in spontaneous labor and has progressed to being fully dilated. She has been actively pushing for 60 minutes. On abdominal examination the head is $0/5^{th}$ palpable. Vaginal examination reveals a DOA position with no caput or moulding. Head station is +2 below the ischial spines.

- What is the best management?

Case 54

A 29- year old PG at term is admitted in spontaneous labor and has progressed to being fully dilated. She has been actively pushing for 90 minutes. On abdominal examination the head is $0/5^{th}$ palpable. Vaginal examination reveals a sagital suture midway between symphysis and coccyx with no caput or moulding. Head station is +1 below the ischial spines.

- What is the best management

Case 55

A 28- year old who is para 2 presents at 12 weeks' gestation with repeated vomiting and malaise. Antiemetics were given but with no improvement in the general condition. Urine analysis showed +1 acetone and pus cells 2-5 /HPF. The patient started to experience fever and vague abdominal pain. U/S was normal, there was no vaginal bleeding. Liver function showed bilirubin 12 mg%, AST 100 IU, ALT 120 IU, elevated alkaline phosphatase.

- **What is your most likely diagnosis** Viral hepatitis

Case 56

A 28- year old lady with a missing period for 2 weeks is represented to you with lower abdominal pain. Preg test in urine was +ve. She has an episode of vomiting in the morning. On examination her temp is 37.8. There is no history of dysuria or vaginal bleeding. There is tenderness in her abdomen particularly in the right lower quadrant. Vaginal examination reveals a closed cervix with no tenderness or palpable adnexae. Blood results: Hb 11.2 , TLC 17.000 /ml^3, CRP 88 units , HCG 2400 , AST 301U , creatinine 0.5 mg%.

- **What is your provisional diagnosis?** Appendicitis
- **What is the differential diagnosis?**
- **How to confirm your diagnosis?**

Case 57

A 29 yr old G5P4 woman presented at 39 wks gestation with PET and persistent abdominal pain. Fetal kicks were not felt for the last 12 hours. On P/V Bishop score was 9 and cervix was 3 cm dilated. Rupture of membranes revealed bloody liquor which was followed by vaginal delivery within 3 hours. After the placenta is delivered, there is appreciable vaginal bleeding estimated at 1000 ml. She denies a family history of bleeding diathesis. There was no bleeding from other sites or hematuria.

What is the most likely diagnosis?

What is your next step in therapy?

What is the best management?

1- A PG in labor with a fully dilated cervix for 2 hours , head station -1 with moulding and diffuse caput

2- Eight minutes after a normal delivery under pudendal anesthesia, the patient has not completed her 3rd stage of labor. The uterus is globular & firm and no bleeding is evident

3- A 26 year old PG who states that she is experiencing regular menstrual cramps every 3 minutes. After taking this history, what is the 1st appropriate thing to be done

4- A 37 yr old G4 P3 presented to the emergency room at 37 wks with mild painless unexplained vaginal bleeding. there are no signs of onset of labor

5- A 21 yr old PG presented in labor at 41 wks. She had ROM 12 hours ago. On examination abdominally baby is cephalic with 2/5th above symphysis. Vaginal examination: 5 cm dilated revealed horse show like bone directed backwards with station -2. FHS are excellent with good variability.

6- A 38 year old G3 P1 Rh-ve who didn't receive anti-d before came to you at 10 weeks gestation with antibody titer 1:4

7- A woman in the second stage of labor came with breech hanging out of the vulva while the head and shoulders are still in the birth tract. The cord is pulsating

8- Another woman who delivered at home since two hours came with the umbilical cord ligated and the placenta is still inside. She looks pale

9- A prolapsed edematous arm from half dilated cervix while uterus is markedly moulded on a transverse lie baby

10- A G6 P5 who is fully dilated for 2 hours with a cephalic baby who has diffuse caput at station +2

11- Passage of painless vaginal fluid at 29 wks in afebrile patient

Gyna	1 (very good)	2 (excellent)	Enumerate
"A"			
Anatomy	Circumcision	- Pelvic blood supply - Ureteric injury sites	- Lymph nodes of pelvis - Comp. & types of circum. * Structures in broad lig.
Embryology	Imperforate hymen	Uterine malf.	
Physiology	GnRH	Est., Prog. Menst cycle	* Uses/funct. of Horm / anti
Pub., menop.	Management of menop. (HRT) Precocious puberty	Menopause	* causes of P.puberty
Amenorrhea	- Anovulation - PCO, hyperprolact, LPD	Amenorrhea Types / Assessment	- Pdf for LPD - Etiology of 1ry / 2ry amen.
Bleeding	Postmenopausal bleeding DUB (metropathia hgica)	Bleeding Classification & etiology	
Pain	- Dysmenorrhea - PMT		* Causes of chronic p. pain * Causes of dysparuenia
Infertility	Assessment of ovary / tube/ ut. Induction of ovulation	- OHSS, unexplained infertility - IVF	- Causes of cx factor * Causes of male infertility
Infection	- PID (acute / chronic) . Chlamydia . Gonorrhea - Vulvovaginitis (children/adults) . Gard.vaginalis . Candida . T.vaginalis		
Contraception	- Natural (phys) contraception - Contraception for lactation - Complications of IUCD - Comp of hormones - Long acting hormonal contr.	Emergency contrac.	- Contraindications of IUD - Comp of IUD - Comp of COC
"B"			
Tumors	- Uterus . Complications of fibroid . Endometrial hyperplasia . Pelvic endometriosis - Cervix . CIN . Pap smear - Ovary . Complications of ovarian cyst . Dermoid cyst of the ovary . Diagnosis & manag. of cr. ov.	- Choriocarcinoma - Operative . Comp. of D&C . Comp / indication of:- Hysterectomy Laparoscopy HSG	- Diagnosis of CIN * causes of contact bleed * causes of barrel shaped cx * causes of uterine swelling * causes of adnexal masses * causes of DP masses * Types of ovarian swellings * causes of vulvar itching * causes of vulvar ulcers * causes of vulvar swellings
Prolapse	Vesico-vaginal fistula	Prolapse ± SUI (mostly clinical	- Types of prolapse / incont.

Case 1

A young newly married lady, 27 years old consulted you on account of heavy periods, which extend over 6-8 days. Bleeding was also associated with severe pelvic pain characteristically starting few days before menses. She gave a past history of a laparotomy ten years earlier to remove an ovarian cyst

On examination: the general condition was normal, but on pelvic examination, the uterus was fixed in an RVF position and there was a tender fixed left adnexal mass 4x6 cm which was ill-defined

endometriosis

- **What is the most probable diagnosis? how to confirm?** Ectopic
- **What is the best management for this lady**
- **What are other causes of adnexal mass & fixed RVF?**
  - PID } causes of
  - Ovarian cancer } frozen
  - Tuberculosis with encysted adhesions } pelvis
- **What are other causes of pelvi-abd swelling & bleeding ?**
  - Complications of pregnancy
  - *Uterine* tumors → fibroid or sarcoma
  - *Cervical* tumors if → pyometra
  - *Tubal comp.* → large tubo-ovarian complex
  - *Ovarian tumors* if . Functioning . Pelvic congestion. 2[ries] to uterus

Case 2

A GMP patient 57 years old, menopausal for the last 7 years, presented with vaginal bleeding mostly in the form of spotting, esp. in the last few weeks

Vaginal speculum examination revealed a small polyp, coming out of the cervical canal.

- **What Is your management** → Polypectomy + D&C.
- **What are different types of polyps?**
- **How to differentiate between them?**

Cervical	Corporal
- Mucous polyp ✓	- Adenomatous
- Inflammatory polyp	- Placental
- Fibroid polyp	- Fibroid
- Malignant polyp	- Malignant

1. Sound & pass it around the polyp:
   - If it passes around → corporal
   - If not → cervical
2. Hysteroscopy ✓
3. HSG
4. Pelvic U/S (less imp)

Case 3

Para 7+0 42 years old, presented with recurrent vaginal bleeding specially on contact for 3 months duration. Pelvic examination revealed a friable cauliflower mass that bleeds easily on touch from the anterior lip of the cervix. Cancer Cx (1A)

- Complete the points in history & examination to justify your diagnosis
- What are the investigations you need in order to reach the final diagnosis biopsy (Dx)
- Mention the different causes of contact bleeding
  - Infection } in cervix, vagina
  - Tumors } pedunculated polypi

Case 4

Dysfunction → Anovulation.

A 36 years old lady, P2+2, presented with vaginal bleeding mostly in the form of metrorrhagia. → ulcer ← abnormal growth, infection.

A cervical smear was done and revealed highly suspicious cells. A cervical cone biopsy was performed and its histopathological report showed CIN III

- Name the type of this smear & state its indications?
  - Any suspicious cervix
  - Routinely
    - .Every 1 year if there are risk factors (HPV, multiple intercourse)
    - .Every 3 years in any normal female

- What are the complications of cone biopsy? & what is the newest alternative
  - Hemorrhage (1^{ry} or 2^{ry})
  - Infection → infertility
  - Cervical stenosis → cervical dystocia
  - Cervical incompetence → abortion or PTL

- What further management will be done
- Would you change your management if the patient had no children
- Would you change your management if the margins of the cone biopsy are infiltrated with malignant cells

Case 5

A 22 year old parous woman complains of a 3 month history of weight loss, nervousness, palpitations and sweating. She denies a history of thyroid disease and is not taking any weight loss medications. She denies abdominal pain or N&V. On examination BPr 110/60, pulse 110 bpm, and she is afebrile. Her thyroid gland is normal to palpation. She doesn't have proptosis or lid-lag. Her abdomen is non-tender and has normal bowel sounds. Her uterus is normal in size. A mobile, non-tender 9-cm mass is palpated on the right side of the pelvis which is not mobile on moving the cervix

- **What is the most likely diagnosis?** (cystic ovary stromal ovary)
- **What is your management for this patient?**

unilateral oophorectomy.

Case 6

A 72 year old lady presents with postmenopausal bleeding / spotting lasting for the past 3 months. She also complains of vaginal bleeding & itching. She had a hysterectomy for a benign ovarian condition 20 years ago. Clinical examination is normal apart from vaginal dryness

- **What is your possible diagnosis & TTT**

atrophic vaginitis

Case 7

A 43 yr old woman is referred to hospital with painful periods for the last 2 years. She bleeds every 24 days with menses lasting for 7-9 days. The pain starts 36 hours before menses and lasts till day 5 bleeding. There is no intermenstrual bleeding or discharge. On abdominal examination there is vague tenderness in the suprapubic area. Bimanual examination revealed a 10 wks sized uterus which is soft. There was no tender motion of the cervix, or adenexal masses. U/S showed a bulky uterus with IUCD inside. Endometrial thickness was 13 mm. Hb was 8.8 mg/dl

- **Discuss differential diagnosis** adenomyosis
- **Establish your management**

1- elvat Hb level
2- Remove IUCD
3- Progesteron - Danazol, LH-RH-analogs

Case 8

A 42 yr old parous woman has noticed increasing hair growth on her face and abdomen over the past 8 months. She denies use of steroid medications, weight change, or a family history of hirsutism. Her menses previously have been monthly and now occur every 35-70 days. On examination her thyroid is normal to palpation. She has excess facial hair and male pattern hair on her abdomen. Abdominal examination reveals no masses or tenderness. She has presented to the emergency room with acute retention of urine. Upon catheterization clitromegaly is noticed. Vaginal examination revealed a mass in the utero-vesical pouch.

- What is the most likely diagnosis? Sertoli Leydig (ovarian cancer)
- What is your probable management?

Case 9

A P1+0 36 years old lady presents with 2ry infertility. She states a two year history of amenorrhea. Her partner's semen analysis is normal. Tubal patency is confirmed on HSG. There was no bleeding after receiving progesterone injection. LH level was 25 mIU/ml and FSH was 38 mIU/ml.

- What is the most appropriate diagnosis Premature ovarian failure.
- Enumerate etiology of such condition

Case 10

A 42 year old lady complains of amenorrhea for 4 months. She also complains of easily fatigability. She gives a history of 6 months' amenorrhea 15 months ago when she was investigated and discharged with normal results. Blood tests were withdrawn: she had a borderline TSH & thyroxine, prolactin 42 ng/ml, normal testosterone, LH 0.3 mIU/ml, FSH 0.4 mIU/ml.

Juvenile?

- State one the most appropriate step in assessment? B HCG

Case 11

A 25 year old lady presents with a 6 months history of 2ry amenorrhea. Her height is 10 cm below her mi-parental height. She started menarche at age of 18. She was increasingly embarrassed from undersized breasts. Pregnancy test is –ve. She received depot-MPA injection 3 weeks ago but nothing improved.

- **What is your possible diagnosis** Turner's (Mosaic)
- **How to confirm such condition** LH & F.H +cary typing

Case 12

A 38 year old woman complains of 7 months amenorrhea following a spontaneous abortion for which she had D&C. her medical and surgical histories are unremarkable. She experienced menarche at 11 yrs and notes her menses have been 28-31 days until recently. Her thyroid is normal to palpation, and breasts are without discharge. The abdomen is non-tender. P/V shows a normal uterus, closed normal appearing cervix with no adenexal masses. A pregnancy test is -ve. LH 6 mIU/ml, FSH 5 mIU/ml. The patient received COC for the last 3 months but there was no withdrawal bleeding.

- **What is the most likely diagnosis?** Asherman's
- **What is your next diagnostic test?**

Case 13

An 11-year-old girl undergoes laparotomy for appendicitis. On opening the abdomen there is noted to be a torted gangrenous ovarian cyst, for which she undergoes a unilateral oophrectomy. Further exploration show a horse-show mass with no palpable uterus or tubes. Vaginal examinat on shows a blind pouch of 3 cm length. Serum FSH, LH and E2 levels re normal.

Mullerian agenesis

Case 14

A 16-year-old girl presents with primary amenorrhoea. Her beast development is Tanner stage 2. Pubic and axillary hair show stage 1 development. U/S shows a uterus 4.5 x 3 x 2 cm. Her height is 140 cm.

Case 15

A 33 years old P 3+2 has come to your office with continuous dribbling of urine from the vagina. Her last 2 deliveries were by CS. In the last delivery, she was allowed to deliver vaginally, but rupture uterus occurred. The rupture was repaired but the patient claims that she is sometimes continent & sometimes not. On examination, the vulva was found to be excoriated with whitish crusts

- What is the type of incontinence present
- What are the conditions that should be fulfilled if a patient with CS is allowed to deliver vaginally
  - One LSCS (Not USCS)
  - No permanent indication → e.g. contracted pelvis
  - No associated indication → e.g. malpresentation or placenta previa
  - No tenderness over scar → also scar doesn't look ugly
  - No previous op. difficulty → no bl. transfusion, bladder injury, p.sepsis

- What are the possible conditions that increase such injury
  - Congenital malformations → of the genital or urinary tract
  - Involvement in adhesions → infection, malignancy, endometriosis
  - Distorted anatomy → cervical fibroid, broad lig. swelling, prolapse
  - Rapid blind clamping → to stop bleeding in massive intraoperative hge.

Case 16

A 64 year old lady presents with heavy postmenopausal bleeding. She has never had a smear. A hard ulcerative lesion was found on the cervix. She complains of leaking clear fluid through the vagina.

- State the complete final diagnosis

Case 17

A30 year-old woman is presented to you 8 weeks after giving birth, and seeks medical help because of urine leakage. She explains that she labored over 3 days without medical assistance, and the baby was eventually stillborn. For the past 4 weeks she has been leaking urine continuously.

- How to establish your diagnosis?

Case 18

A 67 year old who has been menopausal for the past 15 years has come to your office complaining of blood staining of the underwear. On examining her locally, you find that the uterus is atrophic and no masses in the Douglas pouch could be felt. You decide to do a D&C and a large amount of tissue is obtained which were sent for histopathological examination

- What further points in the history could be relevant
  - Ask for etiology:
    - Race & class
    - Menstrual characters
    - Source of estrogen
- What further clinical signs could be found
  - Ask for risk factors
    - Obese
    - Diabetic
    - Hypertensive
    - → mass liver & kidney
- What is the diagnostic procedure more accurate than D&C
- What is the diagnostic procedure that could be done in your office
- What would be the correct treatment in this case
  - TAH BSO & selective lymphadenectomy.

Case 19

A PO+1 young female presented at reception room with a diffuse, but severe abdominal pain for which she had antispasmodic over the past one week.

Her menstruation is irregular over the pat 15 days. She also has a history of vaginal spotting after intercourse for the past year

On examination P 110 b/m, BPr 100/60 T. 37.2, abdominal examination showed diffuse tenderness, but max over the right iliac fossa. P/V revealed tender movement of cervix which looked unhealthy on speculum examination

- What are the 2 possibilities for such story PID, ectopic
- What is the key for diagnosis B.HCG → for ectopic.

Case 20

A 25 year old, married, [illegible] para 1 whose LMP was 4 wks ago, presented to the emergency room with a complaint of lower abdominal pain which began in the right lower quadrant 4 days ago and now is localized in the lower abdomen.

Her temp is 37.9, BPr 120/80, pulse 92 b/m, physical examination demonstrates bilateral lower abdominal pain with adnexal tenderness which is exacerbated with movement of the cervix

An IUCD string is noted protruding from the cervix with a yellow white discharge. She has no nausea, vomiting or dizziness

- What is your provisional diagnosis, how to confirm it
- What are the precautions taken to insert an IUCD to avoid such condition
- What would be the correct treatment in this case
- If large adnexal masses are found, would this change your management?

Case 21

A 17 year old lady has been married for 2 months presents to the clinic complaining that her husband has difficulty in intercourse. During history taking the patient admits to never having a menstrual cycle although she stated that her breasts were normally developed at 12 years. There is no breast discharge & the patient has no other symptoms

On examination, it seems that there is no opening of the vagina and a lower abdominal mass is felt. The ultrasound reveals no uterus and confirms the presence of this mass. Also IVP was requested

- What is the most likely cause of her amenorrhea?
- How would you establish her menstrual pattern?
- Comment on her future fertility
- What are other causes of amenorrhea with present breast?
- Why IVP was asked for

Case 22

A 34 year old lady Para 2+0 has come to your office with 2° infertility for 3 years. Test for ovulation, HSG and laparoscopy show no abnormalities. She gives prior history of repeated cauterization for cervical erosions. A postcoital test is then ordered

- **What would be the proper timing for such procedure**
- **If the results are to be abnormal, give a possible reason and the management in this case**
  - Poor cervical mucus → wrong time of cycle
  - Poor glandular secretion → closed, previous cautery or amputation
  - Infection → prostatitis
  - Immunological factors → cervical mucus (IgG) or in serum (IgM)
- **If this patient were to become pregnant and during delivery, progress was slow, give a possible reason and the management in such a case**

Case 23

A 34-year old woman with a body mass index 36, has a day 23 progesterone of 8 ng/ml. HSG showed patent tubes. Husband analysis showed 3 ml, ph 7, sperm count 20 million/ml. She had tried 6 months of clomiphene citrate with documented anovulation. A trial of metformin was unsuccessful.

- **What is your next plan?**

Case 24

A couple presented to subfertility clinic with FSH 6.1 mIU/ml, LH 4.8 mIU/ml, prolactin 22 ng/ml and day 21 progesterone 20 ng/ml. Laparoscopy done 6 months ago showed normal pelvis with patent tubes. Semen analysis showed volume 3 ml, count 10 million/ml, 18% forward progression, normal forms greater than 50%. No agglutination or white cells were found. No organisms were seen.

- **What is the most appropriate diagnosis**
- **Enumerate etiology of such condition**

Case 25

A 29 year old woman presents with secondary infertility. She had a spontaneous miscarriage 3 years ago followed by an ectopic pregnancy. She was treated for chlamydial infection 4 years ago. She has regular menses with severe colicky pain esp in the 1st two days. Also she suffers from pelvic heaviness lasting for a week before menses and an associating deep dyspareunia. Her partner's semen analysis was normal on 2 different occasions.

- What is the most appropriate diagnosis = chronic PID → HSG → Laparoscopy
- Enumerate etiology of such condition

Case 26

A 31 year old lady presents with secondary infertility. She had difficulty in conceiving her 1st child and has now being trying for 4 years. She gave a history of cyclic premenstrual pains, painful periods and deep dyspareunia. Her day 21 progesterone is 11 ng/ml with normal day 3 gonadotrophin profile.

endometriosis.

- What are clues in history to justify your provisional diagnosis
- How to confirm such diagnosis ? laparoscope

Case 27

A 29 yr old woman is complaining of 1ry infertility. Her husband is medically free apart from smoking 1 box a day. She has no specific previous history except for appendicectomy at 12 yrs. Her BMI is 30 kg/ m2. her periods occur every 31-46 days and can be heavy at times but not painful. Day 3 LH: 6.5 mIU/ml, FSH 2.9 mIU/ml, progesterone day 21: 9 ng/ml.

- What is your provisional diagnosis? PCO
- Complete your infertility work up?
- How to treat such a case?

Case 28

A 22 year old lady Para with anovulation for the past 3 years has been put on clomid and HCG for induction of ovulation but pregnancy has not occurred inspite of continuation of therapy for the past 6 months.

- How was the patient followed during management
- Discuss the possibilities of failure of conception
- What is the next step

Case 29

A 25 year old lady with primary infertility for 3 years has come to the clinic for consultation. Her husband is not with her and he has never been to a doctor before. She has regular periods with colicky lower abdominal pain on the 1st and 2nd days. She has had a previous appendectomy 4 yrs ago, otherwise no history of significance.

Examination revealed a well developed female with normal breast development & no breast discharge. Abdominal examination reveals a clean scar of appendectomy, while pelvic examination is normal

- Do you think this patient is ovulatory? Why ? how would you confirm your diagnosis
- What is the significance of appendectomy?
- What is the first investigation you must order for her? What are the possibilities?
- What are other diagnostic workup for this lady?
  - Ovary
  - Tube
  - Uterus
  - Cervix
  - Vagina
- If every thing is normal, what is the name of her infertility? And how to proceed then in this new situation?

Case 30

A 3 year old female child is referred to you from the pediatric department with the complaint being repeated blood staining of the underwear. On examination you find a breast bud on both sides. You then proceed to order an X-ray of the wrist and a hormonal profile

- What is the most likely diagnosis
- Why was the X-ray ordered →
- Do you want to add CT brain, why? Yes → Tumor
- What hormones would you order → E, اعداد
- What is the further management
- If there was no breast bud, what investigations would you have done
    - General
    - Local

Case 31

A 33 year old woman is admitted to the gynecology ward with abdominal pain and swinging temperature. She was treated from vaginal discharge 2 weeks earlier but no swab was taken. On examination her temp is 38.7 with diffuse rigidity in the lower abdomen. Pregnancy test is –ve. U/S is free.

acute salpingitis or PID — Compelet precous puber [s=sexual

- What is the best management

- Discuss complications

Case 32

A 28 year old woman attends the emergency gynecology clinic with vaginal discharge and abdominal pain. Her LMP was 2 months ago, and an IUCD was fitted 3 months ago.

- Discuss possible management

Case 33

A 23 years old G0 P0 woman complains of lower abdominal tenderness and subjective fever. She states that LMP started 5 days previously and was heavier than usual. She also complains of dyspareunia of recent onset. She denies vaginal discharge or prior sexually transmitted diseases. On examination, BPr 90/70, HR 90 bpm, temp 38.3. Abdomen has slight lower tenderness. On PV: external genitalia are normal. The cervix is somewhat hyperemic, and the uterus as well as the adenexae are somewhat tender. Pregnancy test is -ve.

- What is the most likely diagnosis?
- What are the long term complications that can occur with such condition?

Case 34

A 16 yr old-girl presents with lower abdominal pain which developed suddenly a day ago. The pain is over the whole abdomen but more worse on the right. t was intermittent at 1st but now is constant and more severe. She states that her bowels are opened normally the day before and she had only one attack of vomiting this morning. Her LMP is 2 days late but she states to have slight irregular cycles. On examination: temp 37.9, pulse 112 bpm, BPr 116/74. Abdomen is distended symmetrically with generalized tenderness, max on the right iliac fossa with rebound and guarding.

Appendic. or PID

Discuss further management to reach a final diagnosis

Case 35

A 32 year old lady para 1+4 has come to you with 2ry infertility for 6 years. Her last pregnancy has ended by CS due to APHge. Tests for ovulation show her to be ovulatory and a HSG is ordered

- What are the 2 possible findings that may appear in HSG related to her history
  - Tubal adhesion
  - septum & Bicornual uterus.
- How would you manage each case?
  - laparoscope.
  - sep tum → & erdogl

Case 36

A 29 year old lady with primary infertility for 3 years has been experiencing premenstrual spotting for the past 6 years. On doing an endometrial biopsy on day 22 of the cycle showed: endometrium consistent with day 17 of a normal cycle

- **What is the most likely diagnosis**
- **Enumerate risk factors causing similar situation**
  1. Defect in CL function
     - Normally in → post-menarcheal, post-delivery, pre-menopausal
     - Reduced follicular maturation (↓ FSH & LH....pit or hypothalamic)
     - Clomid use in improper dosage
  2. Early degeneration (luteolysis) of CL
     - Endometriosis (↑ $PG\text{-}F_{2\alpha}$)
     - Hyperprolactinemia, Hyperandrogenism, Hypothyroidism
  3. Endometrial insensitivity to progesterone

- **How would you confirm this diagnosis?**
- **How would you manage such a condition?**

Case 37

A 32 year old lady para 4+2 come to your office complaining of absence of her menstrual flow since her last delivery 8 months ago.

- **Discuss all likely possibilities**
  - ➟
  - ➟
  - ➟
  - ➟

- **How would you reach proper diagnosis & ttt**
  1) First of all → exclude pregnancy → β-HCG
  2) Then determine level → Prolactin & TSH, T_3, T_4
  3) if all normal → Progesterone challenge test
     - +ve bleeding → anovulation
     - -ve bleeding → E + P withdrawal test:
       - -ve bleeding → uterine cause
       - +ve bleeding → central cause: FSH, LH ± CT

Case 38

An 18 year-old female comes into your office for a routine physical examination. She states that her menses began at age 12 years and occurs each month. She has been sexually active for 3 yr and uses COC for birth control. She states that her aunt developed breast cancer at age 60 yr. On examination BPr 100/70, pulse 80 bpm, temp 37. Her thyroid gland is normal on palpation. Heart & lung examinations are normal. Her breasts and pubic hair are Tanner stage IV. She has a normal, nulliparous cervix on speculum examination. Bimanual examination reveals a normal sized uterus with no adenexal masses.

- **What is her investigation needed?** Pap smear

Case 39

A 27 year old NG has come to the clinic with infertility for 2 years and 2^{ry} amenorrhea for the past 5 years. She had had galactorrhea for 4 years. On measuring the prolactin level, it was found 200 ng/ml. The patient was put on drug therapy for 6 months and then refereed to surgery. After the operation, the prolactin level decreased to 16 ng/ml but the menses didn't return and she noticed that her breasts were becoming smaller along with a general feeling of fatigue Pituitary adenoma.

- **What was the surgical procedure done**
- **What are different drugs that may be taken before surgery**
- **What has occurred after the operation & what would be the management**

Case 40

A52-year-old lady was referred to colposcopy with severe atypia. Colposcopy showed changes consistent with CIN III. LLETZ was performed. Histopathology reported a cervical tumour. Excisional margins were clear of the disease.

- **What is the appropriate option?**

Case 41

An 18-yesr old girl presents with urinary frequency. On exam she is found to have a lower abdominal mass. U/S shows 7 cm left ovarian mass with mixed echogenicity. CT confirms the findings with fatty content of the cyst, but no other pathology is seen. CA125 and carcinoemberyonic antigens are normal.

- **What is the management?**

Dermoid cyst.

Case 42

A 34 year old lady who has not been married has come to the clinic with irregular menstrual cycles. She states that her periods lasts for 15 to 20 days but occur every 3 to 4 months.

She also states that she has trouble with excess hair on her face for which she needs to remove frequently.

On examination she is found to be markedly over-weight and her BPr is 150/100. Local examination was not performed and U/S showed enlarged ovaries. Serum FSH 4.6 mIU/ml, serum LH 11 mIU/ml

- What is the most likely diagnosis
- How would you explain the hirsutism in this case
- What are the other causes of hirsutism
  - Increased level of serum androgen
  - Decreased production of SHBG → ↑ free testosterone
  - Local ↑ sensitivity of hair follicles
- Would you advice the patient to reduce weight? Why?
- Would there be any other abnormalities in the uterus found by U/S
- How would you manage such case
- If she is married, would you change your management
- If this patient were to remain untreated, what conditions would she be liable to develop later on
  -
  -
  -

Case 43

A 48 year old woman (para3) represented to the clinic with menorrhagia for one year. Pelvic U/S showed 2 interstial myomas 3 cm and 2 cm in diameter. Blood tests showed Hb: 9.3 and serum FSH 20 mIU/ml → Menopausal

- What is the most accepted line of management here
- Justify your answer

Case 44

A 48 year-old G3 P3 woman complains for a year of a history of loss of urine 4-5 times each day, typically occurring 2-3 seconds after coughing, sneezing or lifting. In addition, she notes some dysuria & these events cause her embarrassment & interfere with her daily activities. The patient is otherwise in good health.

A urine culture performed one month previously was -ve. On examination, she is slightly obese, her BPr. 130 /80, heart rate 80 bpm and temp. 37. Abdominal examination reveals no masses or tenderness. A mid-stream urinalysis is unremarkable

- **What is the possible diagnosis**
- **What are the signs you could elicit clinically**
  - . The cough stress test (ask the patient to cough & observe urine loss)
  - . Bonney elevation test (diagnoses SUI d.t. cystocele)
  - . Yousef test (unmasks hidden SUI d.t. a large cystocele)
  - . Pad test (the patient wears a pad which is re-weighted after a while)
  - . Q-tip test (observe movement of a cotton applicator in the urethra)
- **How to confirm this diagnosis ....** *Urodynamics*
  - . Cystometry (measure ↑ intra-vesical pr. while filling bladder by H_2O)
  - . Urethral pressure (measure ↑ intra-urethral pressure along the urethra)
- **What are the types of incontinence?**
  - *Extra-urethral incontinence* ⇨ fistula
  - *Trans-urethral incontinence*
    - . Retention overflow (false incontinence)
    - . Nocturnal (enuresis) incontinence
    - . Stress incontinence ✓ (60%)
    - . Urgency incontinence = Detrusor instability (20-30%)
- **What is the most important pre-operative investigation?** C&S
- **What is your therapy....surgery**
  - ➠ *Vaginal operations* .....Kelly's operation, TVT
  - ➠ *Abdominal operations*..... Burch colposuspension, MMK

What is the commonest post-operative complication?

- *Retention* of urine due to over-correction
- *Recurrence* of symptoms

Case 45

A 31 year old lady was asking reversal of sterilization. Six years ago, she had been happily married, having 3 healthy children. She has been advised against COC due to varicose veins and as the IUCD caused painful heavy menses, she requested sterilization which was done by laparoscopy. Nine months ago, she was divorced due to betrayal of her husband. Her new partner is eagerly seeking children.

- Comment on the initial decision to sterilize a women at 25 yrs
- What are the absolute contraindications for COC?
  - Patients with history of DVT, pulmonary embolism, CHD
  - Markedly impaired liver function, history of cholestasis in pregnancy
  - Lactation + suspected breast cancer
- What are the other alternative contraception for this lady than sterilization
- What are the hazards of laparoscopic sterilization
  - Anesthesia
  - Early.....hge, injury, infection
  - Special media.....air in laparoscopy
  - Later on.....adhesions
- When to resume relationship after male sterilization?
- What would you do if reversal of sterilization failed

Case 46

A 32 year old diabetic lady complains of vulval fishy odor and a vaginal discharge. Speculum examination revealed whitish adherent patches with a strawberry erythematous cervix. Her husband also complains of dysuria and milky whitish discharge at termination of micturition.

- Discuss possible causes of this discharge & how to manage them

Case 47

A 27 year old married for 10 years was taking COC regularly for the last 2 years. Her menses was delayed for 8 days and she complained from nausea & lower abdominal heaviness.

She was advised to have a pregnancy test. Upon arrival to hospital, she started to complain from heavy attack of vaginal bleeding. Examination revealed an enlarged bulky uterus with opened cervix. Emergency D&C was done but no products of conception were found but instead some yellow fatty tissue were found

- Clarify the reasons of getting pregnant while on pills
- What is the management of
  - Missing pills ➡
  - Missing period ➡
- What is the explanation of the yellow fatty tissue & how to manage
  - Conservative if ➡ mild Bleeding small injury
  - Surgical if ➡
- What are the other complications of D&C
  1. Anesthetic complications
  2. Injury → cervical tears, patulous os
  3. Infection → propylaxis by proper sterilization & antibiotics
  4. Shock →
     . Hemorrhagic (perforation, retained products, 2ry hge)
     . Neurogenic (if without anesthesia)
  5. Incomplete evacuation → inf & hge re-evacuation is done
  6. Later on → Ashermann syndrome (amenorrhea traumatica)

Case 48

A 33 year old woman came to the infertility clinic. She complains of pelvic pain and amenorrhea associated with low grade fever and weight loss. Physical examination demonstrates a tender pelvic cystic swelling with indefinite borders. Laparoscopy was done which revealed dense pelvic adhesions together with segmental dilatation of the tubes and everted fimbria. Biopsy was taken and showed marked infiltration with giant cells

- State the possible lines of therapy for such a patient? FB

Case 49

A 34 year old married lady para 1+1 was referred from the venereal clinic due to acute exacerbation of chronic lower abdominal pain. She gave history of right salpingectomy due to previous ectopic; also appendectomy was done when she was 14 years old.

Two days she gave history of increasing pain in the left iliac fossa. Her LMP was delayed for 5 days. Previous cycles were regular. She had noticed a brown vaginal discharge for 48 hours and she had passed either a clot of blood or some tissues.

General examination was normal & she was afebrile. Pelvic examination showed normal uterine size with marked tenderness on the left side, also a tender left adnexal mass was found.

- Discuss the features with or against:
  - A further ectopic
  - An inevitable abortion
  - Acute PID
  - A complicated ovarian cyst

- State two main investigations that are fundamental for the differentiation

- Discuss your management should she have
  - A further ectopic pregnancy
  - A 10 cm diameter hydrosalpinx
  - A 10 cm diameter ovarian cyst

Case 50

A 24 year old woman G0 married for 5 months presents with a non-tender cystic mass in her right vulva that cause some discomfort during walking and coitus. The mass is at the posterior part of the labium majus and is about 2x2 cm

- What is the diagnosis Bartholin cyst
- What is the best management

Case 51

A 30 year old NG married 2 years ago complained of prolonged heavy periods associated with severe pain during menses. She had always experienced dysmenorrhea during the first day of menses. but for the last 2 years, this pain lasted for more than 3 days together with a suprapubic ache. There was also associating menstrual clots in the last 2 years.

Examination revealed enlarged uterus 14 weeks with a firm right sided fundal fibroid. D&C was performed, same clinical data were confirmed, and simple endometrial hyperplasia was confirmed by histopathology.

HSG proved right tuba block, so laparotomy was decided to remove the fibroid. However, it was found impossible to enucleate the fibroid as no capsule or line of cleavage were found

- What is the mostly diagnosis, why?
- What is the possible etiology?
- How to treat such a condition?
- Would findings on D&C change diagnosis?
- What are the advantages of HSG in infertility
    - Diagnostic ..... tube, uterus, ovary
    - Therapeutic

Case 52

A 35 years gravida 2, para 1 is pregnant now at 32 weeks. She suddenly complained of acute abdominal pain, associated with nausea & vomiting. U/S examination revealed normally situated placenta, normal amount of amniotic fluid & no adnexal swelling; only a large fibroid was seen 8x6 cm.

Medications were given & condition controlled. After delivery, patient was counseled for myomectomy but she refused to perform laparotomy although menses were becoming heavier & more painful

Red degenerated fibroid.

- What is the most probable cause of her acute abdomen?
- Why she is treated medically? When to perform surgery?
- In what circumstances would uterine fibroids cause pain
    -
    -
    -
- What are the other conditions of acute abdomen with pregnancy at 32 weeks?
- After delivery, when could myomectomy be performed?
- What are the alternatives if she is refusing surgery?

Case 53

A 38 years old smoker lady have been advised to stop COC & use an IUCD instead. She started to experience heavy menses in the 1st 3 months but this subsided after a while. Few days ago she started to complain of an acute suprapubic pain with a fainting attack. She also gave history of a vaginal discharge for the lasted two weeks.

On arrival to the hospital, she was feverish, with tender right adnexal swelling & tender movement of the cervix

- What are the causes of acute abdomen due to an IUCD
- What is the most probable diagnosis? why?
- How to treat such a condition?
- What are the most frequent organisms causing her vaginal discharge
- What are the other alternative contraception for this lady

Case 54

Para 3+0 had an IUD inserted one month after delivery. Two months later, she came complaining of amenorrhea & she couldn't feel the threads of IUCD. Speculum examination proved absent thread

- What is the DD
  - perforation
  - expulsion
  - pregnant
- How to manage
  - B-HCG
  -
  -

Case 55

A 55 year postmenopausal lady who is Para 4+2 noticed gradually increasing swelling protruding from her vulva. She also complains of dragging lower abdominal pain. Recently she started to complain of painless loss of urine upon cough.

prolapse (cystocel) => SUI.

- What is the DD
- What are the possible causes

Case 56

A 38 years old smoker lady have experienced heavy vaginal bleeding 2 days ago for which she was transferred immediately to hospital. After receiving 2 units blood, examination revealed no general or abdominal abnormality. However, on examining the cervix it was found to be replaced by a large 4x4 cm mass. Examination under anesthesia was decided to take a biopsy that revealed malignant & extending to the upper 1 cm from the vagina. A weak after the operation, the patient complained form urine dribbling from the vagina Cancer CX IIA

- What are DD of such large cervix
  1-
  2-
  3-
  4-
- What is the stage of that malignancy
- What was the operation done
- How to explain the complication that happened postoperatively, what are the possible risk factors for such complication?
- What is the alternative to surgery? What are its contraindications / disadvantages?
  - **Contraindications**
    - *Presence of Pelvic*
      . infection
      . adhesions
      . associating *pelvic* pathology
    - Relative in *young* patient
    - Radioresistant tumors as in adenocarcinoma
  - **Complications**
    - **Early**..... .....affection of rapidly dividing cells
    - **Late** (EAO) ...GIT (radiation sickness, proctitis, enteritis)
      Urinary (radiation cystitis, fistula)
      Vaginitis & vaginal stenosis / Artificial menopause
      Flaring up of infection

Case 57

A 28 years old housewife with 2 children was referred to the gynecology department due to a vulval swelling. Although this swelling was present for 4 years, however it was painful only 3 days ago. The patient was found feverish and the swelling was tender.

- **What is your provisional diagnosis** Bartholin cyst → Abscess.
  How to treat such condition?
- **What are the causes of vulval swellings**
  1. Congenital ➞ dermoid cyst (may be acquired: implantation)
  2. Traumatic ➞ hematoma (direct / surgical / obstetric)
  3. Inflammatory ➞ Bartholin gland (infection / cyst / tumor)
  4. Neoplastic ➞ Benign / Malignant
  5. Vascular ➞ Varicose veins, Edema, Elephantiasis
  6. Other swellings which may appear at the vulva
     - *Inguinal hernia*
     - *Uterine or vaginal prolapse / inversion*
     - *Tumors & polyps protruding from vulva*
     - *Urethra: urethral caruncle, diverticulum*

Case 58

An 80 years old lady was referred to the gynecology clinic complaining of vulvar pruritis, soreness & swelling for more than 2 months. She was also complaining of vaginal discharge and thought that this is the cause of her condition.

General examination was well, abdominal examination is free. Vaginal examination revealed whitish coloration of the labia minora. Sometimes the skin is thin but in other places it is thickened. There were signs of recent scratching but no signs of ulceration. She had a small rectocele and minimal cystocele. There was no obvious stress incontinence upon cough.

- **What is the condition the patient suffers from**
- **What investigations would you perform to confirm such condition**
  - Search for etiology ⇦ vaginal swabs for candidiasis, GTT
  - Exclude malignancy ⇦ colposcopy + Toluidine blue + multiple biopsy
- **Classify the various appearances which this type of lesion can have**
  - Hypertrophic (sq. cell hyperplasia) } may be
  - Atrophic (lichen sclerosus) } mixed
- **What is the main treatment?**

Case 59

A para 2+2 40 years smoker old housewife was referred for gynecological opinion due to 6 months of amenorrhea. She stated that she was taking previously COC for 5 years but she changed for POP 1 year ago according to her physician request. She was anxious about being pregnant but pregnancy test has proved -ve. She stopped those POP 6 months ago but still her menses didn't resume the normal rhythm.

- Why physician has stopped COC
- What are indications to give POP
  1. *Lactating*
  2. *As there is no estrogen side effects:*
     - CVS.....Liver
     - Old .....smoker
  3. *As there is min. Prog. effect (e.g. CHO, lipid metabolism, weight gain)*
     - Diabetics & hypertensive
     - Obese

- How does POP work?

- What is the patient situation now? How to prove it?

- What are other causes of such situation? ....did by CIA.....

1. Destruction by
   . Chemotherapy
   . Radiotherapy
   . Hysterectomy
2. Idiopathic ➠ commonest
3. Debilitating disease ➠ pernicious anemia
4. Chromosomal ➠ Turner, trisomy 18 or 13
5. Infections ➠ mumps, TB
6. Autoimmune ➠ anti-ovarian antibodies
   .Lymphocytes & plasma cells surrounding follicles (Blizzard syndrome)
   .Hashimoto thyroiditis is associated in 30–50 % of cases

Case 60

A 43 year old divorced lady was admitted in the emergency room suffering from heavy vaginal bleeding for 4 days. On the day of admission she has passed several large blood clots. Her LMP was 4 months earlier. On examination, the patient is found pale, but there were no abdominal or vaginal abnormalities.

- How to manage the acute bleeding
- How to exclude malignancy in such patient
- What is your diagnosis if there investigations failed to find any obvious cause?
- How to treat such condition?

Case 61

An 14 years girl presented to the emergency room with severe suprapubic pain & inability to micturate for 12 hours. She also felt fullness in the lower abdomen. she never menstruated, but she gave the history of periodic colic supra-pubicaly during the last 6 months

- What important sign you can elicit in order to explain the pain & retention of urine
- What is your provisional diagnosis
- What further investigation you suggest to help in diagnosis
- Would you agree to insert a catheter into the bladder as 1st line of management? Why?
- What surgical management do you suggest for such cases
- Is there any administrative (non-medical) part in management of such a case

Case 62

A 15 years old girl complaining of severe dysuria with minimal dribbling of urine as well as severe lower abdominal pain for the last few days. She gave a history of almost similar attacks for the last few months with less intensity. On examination, generally the patient is anxious and is in agony with well developed 2ry sexual ccc. Lower abdomen revealed central swelling reaching the umbilicus & tender on palpation

- **Comment on diagnosis & ttt**

Case 63

A fifty years old housewife had noticed a mass protruding from the vulva of increasing size from 2 years. She has local soreness & associated with a low abdominal dragging sensation. Menstruation had ceased 11 years earlier but for the past 3 months she had been troubled by an intermittent blood stained vaginal discharge. She had no intercourse for some months because of the discomfort it caused.

ON vulval inspection, there were moderate atrophic changes and when the patient was asked to bear down the cervix became visible at the introitus, its surface was ulcerated. When she stood up, the vagina become everted Vaginal wall prolapse

- **What is the diagnosis**
- **What other symptoms may associate this condition**
- **What factors predispose to this condition**
- **What ttt you recommend including the preoperative investigations & preparation**

Case 64

A 62-year-old lady attends the clinic with a mass descending per vagina. She underwent a total abdominal hysterectomy & BSO 10 years ago for severe menorrhagia.

- **What is the possible diagnosis**
- **How to treat**

Case 65

A 22 year's old patient, married since 3 years comes to the outpatient clinic with a history of inability to conceive. Since 2 years she started to complain of severe central lower abdominal pain that occurs 2 days before, continues during menstruation and 2 days after it ends. Pelvic U/S shows empty cavity. The right ovary shows a unilocular cystic mass 5 cm in diameter. The left ovary is normal.

- What is the most probable diagnosis? explain why?
  - History
  - Examination
  - Investigation
- What are the investigations required to confirm the final diagnosis
- What is your plan of ttt

Case 66

A young NG patient is married 6 years ago, but failed to conceive until now, Semen analysis is normal, together as HSG, day 21 progesterone level. The patient has done laparoscopy 2 months ago that proved normal then ART was decided. The patient stared to receive IM injections staring from the 2nd day of the cycle. Suddenly the patient was found dyspneac, with lower abdominal pain.

d HSJ

- What is the most probable diagnosis
- What is the stage of that disease
- How to avoid such condition
- How to treat such conclition

Case 67

A 37 years old MP woman comes to the hospital complaining of severe irregular bleeding, pelvic examination reveals bulky uterus (symmetrically enlarged) and a solid right ovarian tumor. Fractional D&C reveals endometrial hyperplasia

- What is the significance of endometrial hyperplasia? Name the pathological varieties

- What are the possible ovarian tumors? Why?

- Name the preoperative methods for diagnosis of ovarian malignancy in this case

- Name the intra-operative criteria of ovarian malignancy in such case and mention 2 intraoperative investigations for diagnosis of malignancy

- Outline the ttt of this case if the ovarian tumor proves to be
  1- Benign

  2- Malignant stage I

Case 68

A 64 years old para 2-1-0-2 complains of increased abdominal girth and diffuse lower abdominal discomfort for 6 wks. She has noted fullness in the upper abdomen, and in the last 2 wks has developed mild shortness of breath. She is menopausal since she was 50 years old and her past & family history are unremarkable

On examination: she is found pale, with BPr 110/70 mmhg, pulse 88 b/m, RR 28 /m. examination of the lung discloses diminished breath sounds and dullness in the left lung field. Abdomen is distended with prominent fluid wave & shifting dullness.

On bimanual & rectovaginal examination there was 15 x 10 cm irregular nodular mass fixed to the right pelvic wall & extending downwards to the Cul-de-sac. There is nodularity in the Douglas pouch but uterus couldn't be felt.

Investigations:

- Chest x-ray proves left pleural effusion
- Cytology of this fluid proved malignant
- IVP is normal, Barium enema shows displacement of the recto-sigmoid by a pelvic mass
- Paracentesis removed 6000 cc of straw colored ascetic fluid that revealed +ve for malignant cells

- What is the most probable diagnosis
- What is the stage of this disease
- Mention the accepted classification

Neoplastic				Non-neoplastic
1ry			2ry	=
Benign	*Border-line*	*Malignant*		(functional)
	Potentially Malignant	.Epithelial .Germ cell .Sex cord	- Typical - Atypical	

- What is the DD of masses in D.pouch
  1. Uterine ➟ RVF (the most common), posterior wall fibroid
  2. Tubal ➟ Ectopic pregnancy (hydrosalpinx / hematosalpinx / pyosalpinx)
  3. Ovarian ➟ Masses (neoplastic or non-neoplastic)
  4. Douglas Pouch ➟ pelvic hematocele, pelvic abscess
     . Nodules → Endometriosis , T.B., B. , Malignancy
  5. Urinary tract ➟ ectopic kidney

- Discuss the ttt of this patient